Essential Health Benefits: Basic Facts and State Options

Affordable Care Act (ACA) Requirements for Essential Health Benefits (EHB)

- The ACA allows each state to recommend a benchmark plan from a variety of health insurance plans currently offered in the state to be the basis for most individual and small group health plans sold in Illinois.
- A state may recommend a benchmark plan to the Secretary of Health and Human Services (HHS) regardless of whether the state will operate a State-based Exchange, State Partnership Exchange, or Federally-facilitated Exchange.
- The Secretary will make the final decision on a state's benchmark plan regardless of the state's recommendation.
- The benchmark must include benefits in 10 specific categories of services: (1) ambulatory care; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services; (6) prescription drugs; (7) rehabilitative disease management; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.
- States have the flexibility to select a benchmark plan that reflects the scope of services offered by a typical employer health benefit plan.
- Plans sold both inside and outside the Exchange will be required to offer coverage that is of equal or greater value than the benchmark plan the state selects.

Roles for State in Defining EHB:

- States have the choice to recommend an EHB benchmark from the following:
    - The three largest small group plans[1] in the state by enrollment;
    - The three largest state employee health plans by enrollment;
    - The three largest federal employee health plan options by enrollment (FEHBP); or
    - The largest HMO plan[2] offered in the state's commercial market by enrollment.
- Enrollment data is reported by the carriers to HHS.
    - Enrollment data is used from the 1st quarter two years prior to the coverage years (i.e. 3/31/12 for 2014).
- The value of the benefits in the state recommended plan will be used by other insurers as a benchmark to create health plans to be sold in Illinois
    - States do not have the ability to make specific benefit changes to the benchmark plan (*e.g.* add a specific benefit, such as massage therapy to a plan) or to set guidelines around benefit administration, such as the premium, deductibles, co-payments, and other cost-sharing features.

[1] In the three largest "products," which are the services covered as a package by an issuer that may include different plans with different cost-sharing options and riders.

[2] Medicaid HMOs may not be considered.

- Plans can modify coverage within a benefit category so long as they do not reduce the value of coverage.[3]
    - For example, a plan could offer coverage consistent with a benchmark plan offering up to 20 covered physical therapy visits and 10 covered occupational therapy visits by replacing them with up to 10 covered physical therapy visits and up to 20 covered occupational therapy visits, assuming actuarial equivalence and the other criteria are met.
    - HHS notes that this flexibility for insurers will provide greater choice to consumers and promote plan innovation while maintaining a minimum standard for the value of coverage.
- The state will pick a specific insurers' plan to represent the benchmark, this does not mean that only that insurer will be represented in the marketplace; it means that all insurers that sell products inside and outside the Exchange will be required to include, at a minimum, the value of benefits and services dictated by the benchmark plan in their plans.
    - For example, the state may select Benchmark Plan X from Insurer A. Insurer B will then include, at a minimum, the value of benefits and services in Benchmark Plan X in future plans sold by Insurer B.
    - Additionally, if the benchmark plan selected is an HMO that does not mean all plans sold in the market must be an HMO. Plans will continue to be sold under different benefit administration structures such as HMOs, PPOs, etc. but will need to include the benefits and services in the benchmark plan.

<u>Rules for Supplementing missing Benefit Categories:</u>

- Supplementing will be necessary if a benefit category required by the ACA is completely missing from the benchmark plan that is recommended by the state.
- Special substitution rules apply for habilitation and pediatric oral and vision.
    - For Habilitative care, HHS is considering two options for supplementing:
        - Plans must offer habilitative services at parity with rehabilitative services (a plan covering services such as PT, OT and ST for rehabilitation must also cover those services in similar scope, amount, and duration for habilitation), OR
        - Plans have the ability to decide what habilitative services to cover and submit the proposed coverage to HHS. HHS expects to further define habilitative services in the future.
    - For Pediatric oral services the state has the alternative to supplement by selecting:
        - The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment, OR
        - The state's separate Children's Health Insurance Program (CHIP).
    - For Pediatric vision services the state has the alternative to supplement by selecting:

[3] To protect consumers, any scope and duration limitations are subject to review for discriminatory benefit design.

- The FEDVIP vision plan with the largest national enrollment.

Timeline for State Recommendation

- An initial benchmark recommendation must be made to HHS by September 30, 2012.
- If a state does not recommend an EHB, the default plan will apply:
  - The default plan will be the small group plan with the largest enrollment in the state.
  - If the default plan recommended is missing a required benefit category:
    - The next largest plan of the benchmark type (i.e. another small employer plan, state employee plan, FEHBP) is used to set benefits in the missing category; or
    - If none of the plans within benchmark type include the benefit, the state will supplement using the largest FEHBP option.
- After the state has made a recommendation to HHS, HHS will have a public comment period[4] on the plan the state recommended as its benchmark.
- After the federal public comment period, the final, selected benchmark plan will serve as the benchmark for a two year period (2014 and 2015).
- HHS will provide future guidance on reviewing and updating EHB for 2016 and beyond.

Application of EHB

- The final determination of the EHB benchmark plan will apply to most plans in the individual and small group market, including plans sold both inside and outside of the Exchange.
- Self-insured group health plans, large group market coverage, and grandfathered health plans[5] are not required to offer EHB.
- States are required to pay the additional costs for Exchange enrollees for any state mandated benefit features that are not included in the state's EHB benchmark plan.

Process for Public Engagement

- The Health Care Reform Implementation Council (HCRIC) will begin taking public comments through the Governor's Health Reform website, www.healthcarereform.illinois.gov, on Wednesday September 12th. The comment period will close on Wednesday, September 19 at 5 pm.
- The Governor's office will review written comments beginning on Thursday, September 20. The comments will help inform the benchmark selection process.

[4] The time period for public comment has not yet been determined by HHS.

[5] Grandfathered health plans are plans that were created on or before March 23, 2010 and have not made significant changes that reduce benefits or increase costs to consumers.

- The HCRIC will also hold a public meeting on Wednesday September 12 from 3-6 pm on the topic of Essential Health Benefits. The oral testimony given during this meeting will also help inform the benchmark selection process.
- The HCRIC convened a Workgroup on the Essential Health Benefits selection.
    - This workgroup is comprised of subject matter experts in health care services from several state agencies and has convened several times throughout August and September with the goal of making a recommendation on a benchmark plan for Illinois to the Governor's office.
    - The stated goals of the Workgroup include:
        - Recommending a benchmark plan that will provide comprehensive coverage;
        - Recommending a benchmark plan that provides affordable coverage;
        - Recommending a benchmark plan that will be minimally disruptive to the market;
        - Recommending a benchmark plan that includes all state mandated benefits, if possible;
        - As a workgroup, paying special attention to mental health services,
        - As a workgroup, focusing on the benefits and services covered by each potential benchmark plan rather than specific benefit administration features.
- In the spring of 2012, the Department of Insurance commissioned a report from Wakely Consulting Group on EHB.
    - Wakely produced a comparison chart of the ten benchmark plan options in Illinois to better inform the EHB selection process.
    - The comparison chart includes a description of services offered through each plan and the accompanying report includes a relative actuarial assessment of premium impacts.
    - The draft plan comparison chart is available on the Governor's Health Reform website and the final EHB report produced by Wakely will be released in the near future.